

		FOR BHF USE					

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2005
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2005)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: <u>0041632</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																																																							
Facility Name: <u>Heritage Manor East-Beardstown</u>		<p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/05</u> to <u>12/31/05</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p>																																																							
Address: <u>1501 Canal Street</u> <u>Beardstown</u> <u>62618</u>																																																									
<div>NumberCityZip Code</div>																																																									
County: <u>Cass</u>																																																									
Telephone Number: <u>(217) 323-1900</u> Fax # <u>()</u>																																																									
HFS ID Number: <u>370909086016</u>		<table><tr><td rowspan="2">Officer or Administrator of Provider</td><td>(Signed) _____</td><td>(Date) _____</td></tr><tr><td>(Type or Print Name) <u>Craig L. Ater</u></td><td></td></tr><tr><td rowspan="4">Paid Preparer</td><td>(Title) <u>Senior V.P. & CFO</u></td><td></td></tr><tr><td>(Signed) _____</td><td>(Date) _____</td></tr><tr><td>(Print Name and Title) _____</td><td></td></tr><tr><td>(Firm Name & Address) _____</td><td></td></tr><tr><td colspan="2"></td><td colspan="2">(Telephone) <u>()</u> Fax # <u>()</u></td></tr><tr><td colspan="2">Date of Initial License for Current Owners: <u>1996</u></td><td colspan="2" rowspan="5"><p>MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</p></td></tr><tr><td colspan="2">Type of Ownership:</td></tr><tr><td colspan="2"><table><tr><td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td><td><input checked="" type="checkbox"/> PROPRIETARY</td><td><input type="checkbox"/> GOVERNMENTAL</td></tr><tr><td><input type="checkbox"/> Charitable Corp.</td><td><input type="checkbox"/> Individual</td><td><input type="checkbox"/> State</td></tr><tr><td><input type="checkbox"/> Trust</td><td><input type="checkbox"/> Partnership</td><td><input type="checkbox"/> County</td></tr><tr><td>IRS Exemption Code _____</td><td><input type="checkbox"/> Corporation</td><td><input type="checkbox"/> Other _____</td></tr><tr><td></td><td><input checked="" type="checkbox"/> "Sub-S" Corp.</td><td></td></tr><tr><td></td><td><input type="checkbox"/> Limited Liability Co.</td><td></td></tr><tr><td></td><td><input type="checkbox"/> Trust</td><td></td></tr><tr><td></td><td><input type="checkbox"/> Other _____</td><td></td></tr></table></td></tr><tr><td colspan="2">In the event there are further questions about this report, please contact:</td></tr><tr><td colspan="2">Name: <u>Craig Ater</u> Telephone Number: <u>(309) 823-7135</u></td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Date) _____	(Type or Print Name) <u>Craig L. Ater</u>		Paid Preparer	(Title) <u>Senior V.P. & CFO</u>		(Signed) _____	(Date) _____	(Print Name and Title) _____		(Firm Name & Address) _____				(Telephone) <u>()</u> Fax # <u>()</u>		Date of Initial License for Current Owners: <u>1996</u>		<p>MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</p>		Type of Ownership:		<table><tr><td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td><td><input checked="" type="checkbox"/> PROPRIETARY</td><td><input type="checkbox"/> GOVERNMENTAL</td></tr><tr><td><input type="checkbox"/> Charitable Corp.</td><td><input type="checkbox"/> Individual</td><td><input type="checkbox"/> State</td></tr><tr><td><input type="checkbox"/> Trust</td><td><input type="checkbox"/> Partnership</td><td><input type="checkbox"/> County</td></tr><tr><td>IRS Exemption Code _____</td><td><input type="checkbox"/> Corporation</td><td><input type="checkbox"/> Other _____</td></tr><tr><td></td><td><input checked="" type="checkbox"/> "Sub-S" Corp.</td><td></td></tr><tr><td></td><td><input type="checkbox"/> Limited Liability Co.</td><td></td></tr><tr><td></td><td><input type="checkbox"/> Trust</td><td></td></tr><tr><td></td><td><input type="checkbox"/> Other _____</td><td></td></tr></table>		<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input checked="" type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		In the event there are further questions about this report, please contact:		Name: <u>Craig Ater</u> Telephone Number: <u>(309) 823-7135</u>	
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#	0041632	Report Period Beginning:	01/01/05	Ending:	12/31/05
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D. How many bed-hold days during this year were paid by the Department?

0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)

none

F. Does the facility maintain a daily midnight census? yes

YES ☐ NO ☒

YES ☐ NO ☒

Date started 1996

YES ☒ Date _____ NO ☐ **XX**

YES NO If YES, enter number
of beds certified _____ and days of care provided 1,584

Medicare Intermediary Mutual of Omaha

ACCRUAL	<input checked="" type="checkbox"/>	MODIFIED	<input type="checkbox"/>	CASH*	<input type="checkbox"/>
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Is your fiscal year identical to your tax year? YES ☐ NO ☐

*** All facilities other than governmental must report on the accrual basis.**

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	14,227	3,263	1,584	19,074	8
9	SNF/PED			0		9
10	ICF					10
11	ICF/DD					11
12	SC	0	0	0		12
13	DD 16 OR LESS					13
14	TOTALS	14,227	3,263	1,584	19,074	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) **73.60%**

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	118,313	7,719		126,032		126,032	3,134	129,166			1
2	Food Purchase		97,767		97,767		97,767		97,767			2
3	Housekeeping	61,717	10,282		71,999		71,999	3	72,002			3
4	Laundry	21,703	10,389		32,092		32,092		32,092			4
5	Heat and Other Utilities			58,491	58,491		58,491	989	59,480			5
6	Maintenance	27,124	23,118	21,479	71,721		71,721	8,289	80,010			6
7	Other (specify):*											7
8	TOTAL General Services	228,857	149,275	79,970	458,102		458,102	12,415	470,517			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	706,921	46,512	41,101	794,534		794,534		794,534			10
10a	Therapy		101,745	85,117	186,862	(333,400)	(146,538)	211,470	64,932			10a
11	Activities	32,544	1,111		33,655		33,655		33,655			11
12	Social Services	9,605		1,080	10,685		10,685		10,685			12
13	CNA Training	1,193	50		1,243		1,243	1,114	2,357			13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	750,263	149,418	127,298	1,026,979	(333,400)	693,579	212,584	906,163			16
	C. General Administration											
17	Administrative	54,590			54,590		54,590	48,048	102,638			17
18	Directors Fees							3,567	3,567			18
19	Professional Services			131,585	131,585		131,585	(121,675)	9,910			19
20	Dues, Fees, Subscriptions & Promotions			69,350	69,350	(38,873)	30,477	(6,047)	24,430			20
21	Clerical & General Office Expenses	60,832	7,894	16,098	84,824		84,824	99,175	183,999			21
22	Employee Benefits & Payroll Taxes			203,938	203,938		203,938	25,813	229,751			22
23	Inservice Training & Education			1,123	1,123		1,123	836	1,959			23
24	Travel and Seminar			8,549	8,549		8,549	(6,550)	1,999			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			50,050	50,050		50,050	1,266	51,316			26
27	Other (specify):*			4,375	4,375		4,375	(4,375)				27
28	TOTAL General Administration	115,422	7,894	485,068	608,384	(38,873)	569,511	40,058	609,569			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,094,542	306,587	692,336	2,093,465	(372,273)	1,721,192	265,057	1,986,249			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			85,026	85,026		85,026	8,411	93,437			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			74,270	74,270		74,270	14,637	88,907			32
33	Real Estate Taxes			27,608	27,608		27,608		27,608			33
34	Rent-Facility & Grounds							4,344	4,344			34
35	Rent-Equipment & Vehicles			1,510	1,510		1,510	792	2,302			35
36	Other (specify):*											36
37	TOTAL Ownership			188,414	188,414		188,414	28,184	216,598			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					333,400	333,400		333,400			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					38,873	38,873		38,873			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers					372,273	372,273		372,273			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	1,094,542	306,587	880,750	2,281,879		2,281,879	293,241	2,575,120			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(298)	35		5
6	Rented Facility Space		34		6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation		30		9
10	Interest and Other Investment Income	(6)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax		2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions		33		15
16	Personal Expenses (Including Transportation)		24		16
17	Non-Care Related Fees	(905)	20		17
18	Fines and Penalties				18
19	Entertainment	(13,161)	24		19
20	Contributions	(975)	27		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(2,495)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(3,400)	27		24
25	Fund Raising, Advertising and Promotional	(8,158)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule		23		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (29,398)		\$	30

OHF USE ONLY							
48		49		50		51	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	322,639		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 322,639		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ 293,241		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification.

(See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1	\$		1
2			2
3			3
4			4
5		(298)	35
6		0	34
7			7
8			8
9		0	30
10			32
11			11
12			12
13		0	2
14			32
15		0	33
16			24
17		(905)	20
18			18
19			24
20		(975)	27
21			21
22		(2,495)	19
23			23
24		(3,400)	27
25		(8,158)	20
26			26
27			27
28			28
29		0	23
30			30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	Total	(16,231)	49

Summary A

12/31/05

[illegible]

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1OWNERS		2RELATED NURSING HOMES		3OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached						

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1Schedule V		2Line	3Cost Per General LedgerItem	4Amount	5Cost to Related OrganizationName of Related Organization	6Percent of Ownership	7Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			\$			\$	\$	1
2	V	10a	Adjustment for Related Organization						2
3	V								3
4	V	19	Adjustment for Related Organization	129,090	Heritage Enterprises, Inc.	100.00%		(129,090)	4
5	V								5
6	V	10a	Adjustment for Related Organization	101,522	GreenTree Pharmacy	100.00%	312,992	211,470	6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 230,612			\$ 312,992	\$ * 82,380	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐

YES

☐

NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	Dietary	\$	Heritage Enterprises, Inc.	100.00%	\$ 3,134	\$ 3,134	15
16	V	2	Food Purchase				0		16
17	V	3	Housekeeping				3	3	17
18	V	4	Laundry				0		18
19	V	5	Heat & Other Utilities				989	989	19
20	V	6	Maintenance				8,289	8,289	20
21	V	7	Other				0		21
22	V	9	Medical Director				0		22
23	V	10	Nursing & Medical Records				0		23
24	V	11	Activities				0		24
25	V	12	Social Service				0		25
26	V	13	Nurse Aide Training				1,114	1,114	26
27	V	14	Program Transportation				0		27
28	V	15	Other				0		28
29	V	17	Administrative				48,048	48,048	29
30	V	18	Directors Fees				3,567	3,567	30
31	V	19	Professional Services				9,910	9,910	31
32	V	20	Fees, Subscription, Promotions				3,016	3,016	32
33	V	21	Clerical & General Office Expenses				99,175	99,175	33
34	V	22	Employee Benefits & Payroll Taxes				25,813	25,813	34
35	V	23	Inservice Training & Education				836	836	35
36	V	24	Travel and Seminar				6,611	6,611	36
37	V	25	Other Admin. Staff Transportation				0		37
38	V	26	Insurance-Prop.Liab.Malpract				1,266	1,266	38
39	Total			\$			\$ 211,771	\$ * 211,771	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐

YES

☐

NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	27	Other	\$	Heritage Enterprises, Inc.	100.00%	\$	0	15
16	V	30	Depreciation					8,411	16
17	V	31	Amortization of Pre-Op & Org					0	17
18	V	32	Interest					14,643	18
19	V	33	Real Estate Taxes					0	19
20	V	34	Rent-Facility & Grounds					4,344	20
21	V	35	Rent-Equipment & Vehicles					1,090	21
22	V	36	Other					0	22
23	V	38	Medically Nec Transportation					0	23
24	V	39	Ancillary Service Centers					0	24
25	V	40	Barber and Beauty Shops					0	25
26	V	41	Coffee and Gift Shops					0	26
27	V	42	Other					0	27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	0	\$ * 28,488 39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Heritage Manor East-Beardstown # 0041632 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Susie Jefferson	Director	Management	15.86				Salary/BOD	\$ 10,842	Ln 17 & 18	1
2	Estate of Tom Jefferson			16.21				Salary/BOD	0	Ln 17 & 18	2
3	Craig Hart	Chairman	Management	31.95				Salary/BOD	12,159	Ln 17 & 18	3
4	Cheryl Lowney	Executive Vice Presi	Management	0.49		40	100.00	Salary/BOD	7,240	Ln 17 & 18	4
5	Steve Wannemacher	President	Management	0.42		40	100.00	Salary/BOD	9,435	Ln 17 & 18	5
6	Connie Hoselton	Sr Vice President	Management	0.27		40	100.00	Salary	4,655	Ln 17 & 18	6
7	Craig Ater	Sr Vice President	Management	0.34		40	100.00	Salary	5,217	Ln 17 & 18	7
8	Ben Hart	Vice President	Management	3.20		40	100.00	Salary	2,067	Ln 17 & 18	8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 51,615		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

Facility Name & ID Number Heritage Manor East-Beardstown # 0041632 Report Period Beginning: 01/01/05 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization Heritage Enterprises
Street Address 115 W. Jefferson
City / State / Zip Code Bloomington,IL
Phone Number ()
Fax Number ()

B. Show the allocation of costs below. If necessary, please attach worksheets.

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	1	Dietary	Beds	2,612	25	\$ 115,289	\$ 115,276	71	\$ 3,134	1
2	2	Food Purchase	Beds	2,612	25	7	0	71	0	2
3	3	Housekeeping	Beds	2,612	25	124	0	71	3	3
4	4	Laundry	Beds	2,612	25	0	0	71	0	4
5	5	Heat & Other Utilities	Beds	2,612	25	36,387	0	71	989	5
6	6	Maintenance	Beds	2,612	25	304,933	79,110	71	8,289	6
7	7	Other	Beds	2,612	25	0	0	71	0	7
8	9	Medical Director	Beds	2,612	25	0	0	71	0	8
9	10	Nursing & Medical Records	Beds	2,612	25	0	0	71	0	9
10	11	Activities	Beds	2,612	25	0	0	71	0	10
11	12	Social Service	Beds	2,612	25	0	0	71	0	11
12	13	Nurse Aide Training	Beds	2,612	25	40,976	40,976	71	1,114	12
13	14	Program Transportation	Beds	2,612	25	0	0	71	0	13
14	15	Other	Beds	2,612	25	0	0	71	0	14
15	17	Administrative	Beds	2,612	25	1,767,611	1,767,611	71	48,048	15
16	18	Directors Fees	Beds	2,612	25	131,223	0	71	3,567	16
17	19	Professional Services	Beds	2,612	25	364,592	0	71	9,910	17
18	20	Fees, Subscription, Promotions	Beds	2,612	25	110,958	0	71	3,016	18
19	21	Clerical & General Office Expense	Beds	2,612	25	3,648,522	3,309,912	71	99,175	19
20	22	Employee Benefits & Payroll Taxes	Beds	2,612	25	949,625	0	71	25,813	20
21	23	Inservice Training & Education	Beds	2,612	25	30,747	0	71	836	21
22	24	Travel and Seminar	Beds	2,612	25	243,204	0	71	6,611	22
23	25	Other Admin. Staff Transportation	Beds	2,612	25	0	0	71	0	23
24	26	Insurance-Prop.Liab.Malpract	Beds	2,612	25	46,560	0	71	1,266	24
25	TOTALS					\$ 7,790,758	\$ 5,312,885		\$ 211,771	25

Facility Name & ID Number Heritage Manor East-Beardstown # 0041632 Report Period Beginning: 01/01/05 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number
Fax Number

()

()

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	27	Other	Beds	2,612	25	\$	\$	71	\$	1
2	30	Depreciation	Beds	2,612	25	309,426		71	8,411	2
3	31	Amortization of Pre-Op & Org	Beds	2,612	25			71		3
4	32	Interest	Beds	2,612	25	538,695		71	14,643	4
5	33	Real Estate Taxes	Beds	2,612	25			71		5
6	34	Rent-Facility & Grounds	Beds	2,612	25	159,809		71	4,344	6
7	35	Rent-Equipment & Vehicles	Beds	2,612	25	40,093		71	1,090	7
8	36	Other	Beds	2,612	25			71		8
9	38	Medically Nec Transportation	Beds	2,612	25			71		9
10	39	Ancillary Service Centers	Beds	2,612	25			71		10
11	40	Barber and Beauty Shops	Beds	2,612	25			71		11
12	41	Coffee and Gift Shops	Beds	2,612	25			71		12
13	42	Other	Beds	2,612	25			71		13
14								71		14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 1,048,023	\$		\$ 28,488	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3		4		5		6		7		8		9		10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense								
		YES	NO				Original	Balance											
	A. Directly Facility Related																		
	Long-Term																		
1	Bank One		xx	Mortgage	4640 plus Int	01/15/99	\$		\$	1,019,015	01/15/06	variable	\$	62,376	1				
2	Bank One		xx	Mortgage											2				
3															3				
4															4				
5															5				
	Working Capital																		
6	Central Office Allocation		xx	Working Capital										11,894	6				
7	Central Office Allocation		xx	Working Capital											7				
8															8				
9	TOTAL Facility Related						\$		\$	1,019,015			\$	74,270	9				
	B. Non-Facility Related*																		
10	Interest Income													(6)	10				
11															11				
12	Central Office Allocation													14,643	12				
13															13				
14	TOTAL Non-Facility Related						\$		\$				\$	14,637	14				
15	TOTALS (line 9+line14)						\$		\$	1,019,015			\$	88,907	15				

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ Line #

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

		Important , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2004 report.				\$	24,2551
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)				\$	25,3002
3. Under or (over) accrual (line 2 minus line 1).				\$	1,0453
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	26,5634
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)				\$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)				\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.				\$	27,6087
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2000	19,859	8	
		2001	20,563	9	
		2002	22,281	10	
		2003	22,916	11	
		2004	23,197	12	
				13	FROM R. E. TAX STATEMENT FOR 2004 \$13
				14	PLUS APPEAL COST FROM LINE 5 \$14
				15	LESS REFUND FROM LINE 6 \$15
				16	AMOUNT TO USE FOR RATE CALCULATION \$16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.

2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Heritage Manor East-Beardstown COUNTY Cass

FACILITY IDPH LICENSE NUMBER 0041632

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE () FAX #: ()

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2004.

(A)	(B)	(C)	(D)
			<u>Tax</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Applicable to</u>
			<u>Nursing Home</u>
1. 03-264-007-00	Heritage Manor East-Beardstown	\$ 25,300.00	\$ 25,300.00
2.		\$	\$
3.		\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 25,300.00	\$ 25,300.00

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet:

9,428

B. General Construction Type:

Exterior

brick/wood

Frame

wood

Number of Stories

1

C. Does the Operating Entity?

xx

(a) Own the Facility

(b) Rent from a Related Organization.

(c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?

xx

(a) Own the Equipment

(b) Rent equipment from a Related Organization.

(c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

none

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

YES

xx

NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1				\$ 40,000	1
2					2
3	TOTALS			\$ 40,000	3

XI. OWNERSHIP COSTS (continued)											
B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.											
	1	FOR BHF USE ONLY	2	3	4	5	6	7	8	9	
	Beds*		Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	71				\$ 1,744,500	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Shower Remodel			1997	9,921						9
10	Heat/Cool Units			1997	2,138						10
11	Roof			1997	101,691						11
12	Interior Rehab			1997	87,411						12
13											13
14	Five Ton Heat Pump			1996	3,257						14
15	Heritage Manor Sign			1996	2,145						15
16	Remodel Physical Therapy Room			1996	18,303						16
17											17
18	Smoke Detectors			1998	5,431						18
19	Back Flow Preventers			1998	3,155						19
20	Interior Rehab			1998	144,749						20
21											21
22	Water Heater			1999	3,991						22
23	Alzheimer Unit--material			1999	51,576						23
24	Alzheimer Unit--Labor			1999	14,502						24
25	Alzheimer Unit--Professional Fees			1999	21,605						25
26	Interior Rehab			1999	30,944						26
27											27
28	Alzheimer Unit--material			2000	27,447						28
29	Alzheimer Unit--Labor			2000	5,812						29
30	Alzheimer Unit--Professional Fees			2000	1,310						30
31	Fire Alarm Panel			2001	2,026						31
32	Electric Door			2001	2,378						32
33											33
34	C/O Allocation							8,411	8,411		34
35	Book Depreciation					76,435		76,435		673,658	35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37			\$	\$		\$	\$		37
38	Heat/Cool Unit	2002	742						38
39	Heat/Cool Unit	2002	1,190						39
40									40
41	Heat Cool Unit	2003	104						41
42	Service Sink	2003	691						42
43	Security System	2003	2,160						43
44	Compressor	2003	2,244						44
45	Excerciser Clock	2003	1,243						45
46	A/C Unit	2003	568						46
47									47
48	Carpet	2004	3,280						48
49	Heat/Cool Unit	2004	2,877						49
50	Condensing Unit	2004	1,861						50
51	Electronic Door	2004	624						51
52									52
53	Ansul Sustem	2005	2,260						53
54	Hvac System	2005	2,620						54
55	Sidewalks	2005	7,106						55
56	Condensing Unit	2005	3,923						56
57	Shower repair	2005	320						57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$2,318,105	\$76,435		\$84,846	\$8,411	\$673,658	70

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$2,318,105	\$76,435		\$84,846	\$8,411	\$673,658	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$2,318,105	\$76,435		\$84,846	\$8,411	\$673,658	34

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$252,077	\$8,591	\$8,591	\$		\$227,576	71
72	Current Year Purchases	15,473						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$267,550	\$8,591	\$8,591	\$		\$227,576	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

	1	2	
	Reference	Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$2,625,655	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$85,026	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$93,437	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$8,411	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$901,234	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions.
- ☐ YES
- ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease
-
-

9. Option to Buy:
- ☐ YES
- ☐ NO
- Terms:
-
- *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?
- ☐ YES
- ☐ NO
16. Rental Amount for movable equipment: \$ 2,302
- Description:
-

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning

Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2006	\$
13.	/2007	\$
14.	/2008	\$

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES
☐ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM☐

IN OTHER FACILITY☐

COMMUNITY COLLEGE☐

HOURS PER CNA_____

3. CLINICAL PORTION:

IN-HOUSE PROGRAM☐

IN OTHER FACILITY☐

HOURS PER CNA_____

B. EXPENSES

		ALLOCATION OF COSTS (d)			
		1	2	3	4
		Facility		Contract	Total
		Drop-outs	Completed		
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies		50		50
3	Classroom Wages (a)		1,193		1,193
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$ 1,243	\$	\$ 1,243
10	SUM OF line 9, col. 1 and 2 (e)	\$ 1,243			

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

\$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost						
					Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$ 25,100	\$		\$ 25,100	1
2	Licensed Speech and Language Development Therapist		hrs			9,402			9,402	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			30,275	155		30,430	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts				313,060		313,060	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):					20,340			20,340	13
14	TOTAL			\$		\$ 85,117	\$ 313,215		\$ 398,332	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 27,179	\$	1
2	Cash-Patient Deposits	19,809		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	329,043		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	14,001		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	(1,724,795)		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ (1,334,763)	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	40,000		13
14	Buildings, at Historical Cost	2,318,107		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	267,550		16
17	Accumulated Depreciation (book methods)	(901,234)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,724,423	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 389,660	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 46,899	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	19,810		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	108,714		30
31	Accrued Taxes Payable (excluding real estate taxes)	1,102		31
32	Accrued Real Estate Taxes(Sch.IX-B)	26,563		32
33	Accrued Interest Payable	5,353		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 208,441	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	1,019,015		40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 1,019,015	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,227,456	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (837,796)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 389,660	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (697,785)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (697,785)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(140,011)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (140,011)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (837,796)	24 *

* This must agree with page 17, line 47.

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

1			
	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 2,190,183	1
2	Discounts and Allowances for all Levels	(435,705)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,754,478	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	199,182	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 199,182	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	859	12
13	Barber and Beauty Care	332	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	178,779	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	8,232	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 188,202	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	6	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 6	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,141,868	30

2			
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	458,102	31
32	Health Care	1,026,979	32
33	General Administration	608,384	33
	B. Capital Expense		
34	Ownership	188,414	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,281,879	40
41	Income before Income Taxes (line 30 minus line 40)**	(140,011)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (140,011)	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,760	2,119	\$ 40,254	\$ 19.00	1
2	Assistant Director of Nursing			0		2
3	Registered Nurses	3,611	3,929	75,772	19.29	3
4	Licensed Practical Nurses	12,361	13,631	180,568	13.25	4
5	CNAs & Orderlies	38,649	41,931	392,370	9.36	5
6	CNA Trainees			1,193		6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,592	1,777	17,957	10.11	8
9	Activity Director					9
10	Activity Assistants	3,897	4,129	32,544	7.88	10
11	Social Service Workers	1,000	1,000	9,605	9.61	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	14,153	14,632	118,313	8.09	15
16	Dishwashers					16
17	Maintenance Workers	1,918	2,100	27,124	12.92	17
18	Housekeepers	8,070	8,608	61,717	7.17	18
19	Laundry	1,976	2,135	21,703	10.17	19
20	Administrator	1,900	2,080	54,590	26.25	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,128	5,695	60,832	10.68	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	96,015	103,766	\$ 1,094,542 *	\$ 10.55	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		\$ 0		35
36	Medical Director		0		36
37	Medical Records Consultant		5,560		37
38	Nurse Consultant				38
39	Pharmacist Consultant		2,214		39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant		1,080		45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 8,854		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	0	\$ 0		50
51	Licensed Practical Nurses	1,250	31,240		51
52	Certified Nurse Assistants/Aides	0	0		52
53	TOTAL (lines 50 - 52)	1,250	\$ 31,240		53

(See instructions.)

[illegible]

Facility Name & ID Number Heritage Manor East-Beardstown

0041632

Report Period Beginning: 01/01/05

Ending: 12/31/05

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? no
- (2) Are there any dues to nursing home associations included on the cost report? yes
If YES, give association name and amount. Illinois Healthcare Association
- (3) Did the nursing home make political contributions or payments to a political action organization? yes If YES, have these costs been properly adjusted out of the cost report? yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? no If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? yes
What was the average life used for new equipment added during this period? 7 years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 5,000 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? no
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES xx NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO xx If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 38,873
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? no If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? yes For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? yes Indicate the amount. \$ 3,055
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? no
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? no If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 100%
d. Have vehicle usage logs been maintained? yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? yes
g. Does the facility transport residents to and from day training? no
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? yes
Firm Name: Sulaski & Webb The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? No If no, please explain. Not available
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? yes
Attach invoices and a summary of services for all architect and appraisal fees.

					2,612	71	3,471,750	71,391,262		
Name	Title	Function	Total Pay	usted by Mgmt F	total # Bed	acility # Beon-Nursing Hor	Nursing Home	This Facility		
### Susie Jefferson	Director	Managem	418,245	418,245		19,396	398,849	10,842		
### Tom Jefferson	Secretary	Managem	0	0		0	0	0		
### Craig Hart	Chairman	Managem	469,049	469,049		21,752	447,297	12,159		
### Cheryl Lowney	Executive Vice Presic	Managem	279,290	279,290		12,952	266,338	7,240		
### Steve Wannemache	President	Managem	363,969	363,969		16,879	347,090	9,435		
### Connie Hoselton	Sr Vice President	Managem	179,584	179,584		8,328	171,256	4,655		
### Craig Ater	Sr Vice President	Managem	201,279	201,279		9,334	191,945	5,217		
Ben Hart			79,758	79,758		3,699	76,059	2,067		
13			1,991,174	1,991,174			1,898,834	51,615		